



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH HEB
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name

NEW HAMPSHIRE INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-2364-01

MFDR Date Received

March 13, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit they have not paid what we determine is the correct allowable per the new fee schedule that took effect in March of 2008 for this outpatient surgery. . . . For all of the APC allowable the amount due totaled is \$9,931.18. Based on their payment of \$6,537.31 for the APC a supplemental payment is still due of \$3,393.87 on the APC alone, at this time."

Amount in Dispute: \$3,393.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier relies upon its review and reduction of the provider's bill as reflected in its EOBs. The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made."

Response Submitted by: Flahive, Ogden & Latson, Post Office Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 13, 2011 to July 18, 2011	Outpatient Hospital Services	\$3,393.87	\$3,032.18

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
- 97 – (97) THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
 - W1 – (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
 - BL – CV: THIS CHARGE WAS REVIEWED THROUGH THE CLINICAL VALIDATION PROGRAM
 - 94 – (94) PROCESSED IN EXCESS OF CHARGES.
 - BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL. ALLOWANCE AMOUNTS DO NOT REFLECT PREVIOUS PAYMENTS.
 - BL – ADDITIONAL ALLOWANCE IS NOT RECOMMENDED AS THIS CLAIM WAS PAID IN ACCORDANCE WITH STATE GUIDELINES, USUAL/CUSTOMARY POLICIES, OR THE PROVIDER
 - W1 – (W1) THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF THIS PREVIOUSLY REVIEWED BILL.
 - 97 – (97) THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF THIS PREVIOUSLY REVIEWED BILL.
 - 94 – (94) THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF THIS PREVIOUSLY REVIEWED BILL.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code L3660 represents an orthotic device paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the *Medical Fee Guideline for Professional Services*, §134.203(d)(1). Per CMS Manual System, CMS Publication 100-20, Transmittal 833, the 2011 Texas fee listed for this procedure code is \$85.06. 125% of this amount is \$106.33. Reimbursement is the lesser of the MAR or the provider's usual and customary charge of \$18.75. The recommended payment is \$18.75.
 - Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the *Medical Fee Guideline for Professional Services*, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75. The recommended payment is \$3.75.

- Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$14.87. 125% of this amount is \$18.59. The recommended payment is \$18.59.
- Procedure code 88304 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0343, which, per OPPS Addendum A, has a payment rate of \$36.48. This amount multiplied by 60% yields an unadjusted labor-related amount of \$21.89. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$20.93. The non-labor related portion is 40% of the APC rate or \$14.59. The sum of the labor and non-labor related amounts is \$35.52. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service is \$35.52. This amount multiplied by 200% yields a MAR of \$71.04.
- Procedure code 88311 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0342, which, per OPPS Addendum A, has a payment rate of \$11.04. This amount multiplied by 60% yields an unadjusted labor-related amount of \$6.62. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$6.33. The non-labor related portion is 40% of the APC rate or \$4.42. The sum of the labor and non-labor related amounts is \$10.75. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service is \$10.75. This amount multiplied by 200% yields a MAR of \$21.50.
- Procedure code 23410 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0051, which, per OPPS Addendum A, has a payment rate of \$3,259.30. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,955.58. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$1,869.73. The non-labor related portion is 40% of the APC rate or \$1,303.72. The sum of the labor and non-labor related amounts is \$3,173.45. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$1,586.73 divided by the sum of all S and T APC payments of \$4,861.94 gives an APC payment ratio of 0.326357, multiplied by the sum of all S and T line charges of \$6,702.75, yields a new charge amount of \$2,187.49 for the purpose of outlier calculation. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service, including any applicable outlier payment or multiple procedure discount, is \$1,586.73. This amount multiplied by 200% yields a MAR of \$3,173.46.
- Procedure code 29826 is a component service of procedure code 23410 performed on the same date. Per Medicare policy, these two codes may not be reported on the same date of service unless a modifier is appended to the component code to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Review of the submitted medical documentation finds that modifier 59 is supported; therefore, separate payment is allowed. Procedure code 29826 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0042, which, per OPPS Addendum A, has a payment rate of \$3,336.55. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,001.93. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$1,914.05. The non-labor related portion is 40% of the APC rate or \$1,334.62. The sum of the labor and non-labor related amounts is \$3,248.67. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$3,248.67 divided by the sum of all S and T APC payments of \$4,861.94

gives an APC payment ratio of 0.668184, multiplied by the sum of all S and T line charges of \$6,702.75, yields a new charge amount of \$4,478.67 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.239. This ratio multiplied by the billed charge of \$0.00 yields a cost of \$1,070.40. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of \$3,248.67 divided by the sum of all APC payments is 66.19%. The sum of all packaged costs is \$3,241.83. The allocated portion of packaged costs is \$2,145.72. This amount added to the service cost yields a total cost of \$3,216.12. The cost of this service exceeds the annual fixed-dollar threshold of \$2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is \$0.00. The total APC payment for this service, including multiple procedure discount, is \$3,248.67. This amount multiplied by 200% yields a MAR of \$6,497.34.

- Per Medicare policy, procedure code 64415 is unbundled. This procedure is a component service of procedure code 23410 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
 - Procedure code J0171 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J1100 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J2765 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code 93005 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0099, which, per OPPS Addendum A, has a payment rate of \$27.26. This amount multiplied by 60% yields an unadjusted labor-related amount of \$16.36. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$15.64. The non-labor related portion is 40% of the APC rate or \$10.90. The sum of the labor and non-labor related amounts is \$26.54. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$26.54 divided by the sum of all S and T APC payments of \$4,861.94 gives an APC payment ratio of 0.005459, multiplied by the sum of all S and T line charges of \$6,702.75, yields a new charge amount of \$36.59 for the purpose of outlier calculation. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service, including any applicable outlier payment, is \$26.54. This amount multiplied by 200% yields a MAR of \$53.08.
4. The total allowable reimbursement for the services in dispute is \$9,857.51. This amount less the amount previously paid by the insurance carrier of \$6,825.33 leaves an amount due to the requestor of \$3,032.18. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$3,032.18.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$3,032.18, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	<u>Grayson Richardson</u>	<u>October 31, 2012</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.